Evidence for change of age is shown on

FILM No. G96 JUN 21 1945

STATE OF MARYLAND—CERTIFICATE OF DEATH

66161

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Montgomery Co — Registration Dist. No. 214

Village or City Silver Springs — No. 926 Wayne St., Av. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U.S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Frank M. Abeel — If U. S. Veteran, specify WAR no

(a) Residence: No. 926 Wayne St., Ward. (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Toler Abeel

6. DATE OF BIRTH (month, day, and year) Feb 29 - 88

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
57 56			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Construction Eng.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. War Dept

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) New York State

FATHER

13. NAME Chas Abeel

14. BIRTHPLACE (city or town) (State or country) N. Y. State

MOTHER

15. MAIDEN NAME Anna Smith

16. BIRTHPLACE (city or town) (State or country) N. Y. State

17. INFORMANT Carolyn Abeel Paddon

(Address) 512 Leighton Av. S.S.

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Ft Lincoln — Date Jun 6, 1945

19. UNDERTAKER Frank Joel

(Address) 540 ½ Ill Av. N.W.

20. FILED June 4, 1945 Josephine M Schaeffer, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June (Month) 4 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1940, to June 4, 1945

I last saw him alive on June 1, 1945 death is said to have occurred on the date stated above, at 3:00 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cause	Date of onset
Coronary occlusion	6/4/45
Arteriosclerotic heart dis.	4 yrs.

Other Contributory Causes of Importance:

Name of operation None — Date of —

What test confirmed diagnosis? Clinical — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19—

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) W. J. McNeil, M. D.

(Address) Silver Spring, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06162

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? five days
Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? five days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 932 K St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ALEXANDER, Howard Duncan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Gertrude Alexander
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 27 Oct. 1877

8. AGE: Years	Months	Days	If less than one day
67	7	10	hrs. min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Painter - Local No 368
11. Industry or business:
FATHER 12. Name: Henry Alexander
13. Birthplace: Penn. (deceased)
MOTHER 14. Maiden name: Elizabeth Smith
15. Birthplace: Ohio (deceased)
16. Informant: Wife: Mrs. Gertrude A. Alexander
Address: 932 K St., N. W., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof 6-11-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. W. Chambers
Address: 517 11th St., S.E., Wash., D.C.
19. June 8 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 June 1945 at 10:35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 June 1945 to 7 June 1945 and that I last saw him alive on 7 June 1945

Immediate cause of death	DURATION
Coronary Heart Disease Sclerosis with Cardiac Decompensation	7 days
Due to:	
Due to:	
Other conditions: Uremia	4 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Seymour J. Gray, M.D. M. D. or other
Address: USNH Bethesda, Md. Date signed: 6-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

6/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

06763

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17th & K, N.W. "Washington Club"
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen C. Avery
Mrs. ~~Rose~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Maj. Frank Porter Avery (deceased) 6.(c) If alive, give age years

7. Birthdate of deceased (mo., day, yr.) Dec. 26, 1862

8. AGE: Years 82 | Months 5 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Reynolds Washington, Son-in-law
Address Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/7/45 (month) (day) (year)

Cemetery or crematory
Location Washington D.C.

18. Funeral director Martin W. Hysong Co.
Address 1300 N St. NW Washington DC

19. June 4 19 45 (Date rec'd by registrar) J. Walton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 45 at 3 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1945 to June 4 1945 and that I last saw h... alive on June 3, 1945

Immediate cause of death Senile deterioration, simple

Due to Arteriosclerosis, general

Due to

Other conditions Arthritis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE Henry S. Brown M.D.
M. D. or other
Address Takoma Park Md. Date signed 6/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

06164

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Montgomery Co. Gen. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Laytonsville

(If ontside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Susie R. Ayton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Single

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1870

8. AGE:

Years	Months	Days	If less than one day
74	5	23	hrs. min.

9. Birthplace Montg. Co., Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name John S. Ayton

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Ellen Ray

15. Birthplace Maryland

16. Informant Hospital Records

Address Olney, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20 1945 (month) (day) (year)

Cemetery or crematory Laytonsville M.E.

Location Montgomery County

18. Funeral director Roby W. Baker

Address Laytonsville Md

19. June 18 1945 Gertrude B. Lawson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1945, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 8 1945, to June 17 1945, and that I last saw h.e.r. alive on June 17 1945.

	DURATION
Immediate cause of death: Acute Nephritis with Uremia and Myocarditis	17 Days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Charles Sumbleson M. D. or other

Address Sandy Spring Md. Date signed 6/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM No. G 96 JUL 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93

CERTIFICATE OF DEATH

06165

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Monty.
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
5311 Moorland La.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5311 Moorland Lane.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BARNES - Mrs. Mary

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife George Henry
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21, 1866

8. AGE: Years	Months	Days	If less than one day
78	-79-		..... hrs. ..... min.

9. Birthplace Ogdenburg N.Y. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Timothy Berman
13. Birthplace New York
MOTHER 14. Maiden name Mary Wells
15. Birthplace N.Y.
16. Informant Mrs. M.E. Gilmore
Address 5311 Moorland La.
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 6/19/45 (month) (day) (year)
Cemetery or crematory Rye, N.Y.
Location Rye N.Y.
18. Funeral director Wm Rebilen Dumphrey
Address 7557 Wis. Ave. Bethesda, Md.
19. 6/20 1945 Wm E Jolley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1945, at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944, to June 18, 1945
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocardial degeneration	
Uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury (Wyath Post Baker) Injured at work?

23. SIGNATURE Wyath Post Baker M. D. or other
Address 1861 Wyo. Ave. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

C6166

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Col. County

City or town Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 925 Delafield Place, N.W. Wash. D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Beale, — unnamed

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of ~~husband~~ Father or wife Mr. Thomas Lane Beale

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) June 13, 1945

8. AGE: Years	Months	Days	If less than one day
		1	....hrs. ....min.

9. Birthplace Takoma Park, Washington, D.C. (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER

12. Name Mr. Thomas Lane Beale

13. Birthplace Asheville, N.C.

MOTHER

14. Maiden name Anna June Harding

15. Birthplace Duluth, Minn.

16. Informant Washington Sanitarium Hospital

Address Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15 1945 (month) (day) (year)

Cemetery or crematory Forest Washington Memorial Cemetery

Location Silver Spring Maryland

18. Funeral director J. Arthur Walter by H.M. Clay

Address 25 E. Carroll St. D.C. Takoma Park D.C.

19. June 14 1945 (Date rec'd by registrar) J. Arthur Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13th 1945, at ....M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ....19...., to ....19....

and that I last saw h... alive on ....19....

	DURATION
Immediate cause of death Atelectasis	
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Ewart M.D. M. D. or other

Address 4847 - 2nd Ave. Date signed 6-16-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

06167

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 14 hours 57 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda 14
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4604 Rosedale Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Infant Girl Best

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Newborn
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 18, 1945
8. AGE: Years | Months | Days | If less than one day: 14 hrs. 57 min.
9. Birthplace: Bethesda Montgomery Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: John Henry Best
13. Birthplace: Frederick, Maryland
MOTHER 14. Maiden name: Evelyn Lorena Daley
15. Birthplace: Augusta Co., Virginia
16. Informant:
Address:
17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director:
Address:
19. 6/20/1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1945 at 8:48 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1945, to June 19, 1945
and that I last saw h... alive on June 19, 1945

	DURATION
Immediate cause of death: Premature	
Due to: Unknown	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: 8016 Georgetown Rd. Bethesda, Md. Date signed: 6/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06168

CERTIFICATE OF DEATH

Reg. Dist. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (Suburban Hosp)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hosp.

How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9105 Fairview Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Julia Bland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	married

6.(b) Name of husband or wife: John D Bland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 25, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	28	..... hrs. ..... min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Patrick Sullivan

13. Birthplace: Ireland

MOTHER 14. Maiden name: Broderick

15. Birthplace: Ireland

16. Informant: Julia M. Bland (daughter)

Address: Same

17. (Burial, cremation, or removal. Which?) Removal Date thereof June 27 1945 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cemetery

Location: Hyatt. D. C.

18. Funeral director: The J. H. Hines Co.

Address: 2901 - 14th St. N.W.

19. 6/24 1945 Wm E Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-24 1945, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 23 1945, to June 24 1945

and that I last saw her alive on June 24 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	18 hours
Due to: Hypertension	
Due to:	
Other conditions: Hypertensive heart disease (Duration unknown)	12 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. N. Andrews M.D. M. D. or other

Address: 960 Colesville Rd Silver Spring Md. Date signed 6-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (146-C)

CERTIFICATE OF DEATH

T 06169

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~Hadney~~

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 1½ days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Westmoreland Hills

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Westmoreland Drive.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Boswell, Clara

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William Boswell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 6, 1909

8. AGE: Years	Months	Days	If less than one day
36	2	6	..... hrs. ..... min.

9. Birthplace: Toronto, Canada (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: T. H. Bower

13. Birthplace: England

MOTHER — 14. Maiden name:

15. Birthplace:

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14, 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington, D.C.

19. Funeral director: J. W. Ireland Sons Co

Address: 300 - 4 St. N.E. - D.C.

19. 6/12 19 45 Mrs E Jones (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 19 45, at 8 40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 9 19 44, to June 12 19 45 and that I last saw h[er] alive on June 12 19 45

Immediate cause of death	DURATION
Post-Partum Hemorrhage	4 hrs.
Due to (Non-clotting of blood)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Karl Gottlieb M.D. M. D. or other

Address: 3130 Wis Ave D.C. Date signed: 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Wm Hodges
Maryland Hotel
No. 3000

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

06170

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Gist Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: ERNEST BURRELL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 9 1880

8. AGE: Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: U.S. Navy Dept

FATHER
12. Name: Arthur Burrell
13. Birthplace: England

MOTHER
14. Maiden name: Fannie Smith
15. Birthplace: England

16. Informant: Miss Mary Edith Burrell
Address: 705 Gist Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D.C.

18. Funeral director: J. William Lee's Sons Co.

Address: 300 -4th, St. N.E. Washington, D.C.

19. June 24 19 45 (Date rec'd by registrar) Josephine M. Scheffler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 19 45 at 2A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 19 45 to June 23 19 45 and that I last saw h.. l.. alive on June 22 19 45

Immediate cause of death	DURATION
Carcinoma of Throat	5 Mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harold Thorgen M.D.
M. D. or other

Address: Maryland Hotel Date signed 6/23/45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

6171

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/4 hrs.

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 3 1/4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Col. County

City or town Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5619 1st Place - N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cannon - unnamed.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1945

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 1/4 min.

9. Birthplace Takoma Park, Maryland (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Mr. Joseph Lee Cannon Jr.

FATHER 13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Yvonne Zollinhofer

MOTHER 15. Birthplace Baltimore, Md.

16. Informant Washington Sanitarium & Hospital

Address Takoma Park, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 16 1945 (month) (day) (year)

Cemetery or crematory Washington, D.C.

Location 436 - 7th St. S.W. Wash. D.C.

18. Funeral director P. C. Saltzman

Address 436 - 7th St. S.W. Washington D.C.

19. June 16 1945 (Date rec'd by registrar) J. William Doll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 June 1945 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9:15 A.M. 15 June 1945 to 12:30 P.M. 15 June 1945 and that I last saw her alive on 15 June 1945

Immediate cause of death	DURATION
RESPIRATORY AND CARDIAC FAILURE	
Due to PREMATURITY	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clarence D. Bruce M.D. M. D. or other

Address 15 Carroll Ave Takoma Park - Md. Date signed 15 June 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-E)

CERTIFICATE OF DEATH

06172

Reg. Diat. No. 213-

1. PLACE OF DEATH:

County MONTGOMERY

City or town ROCKVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MONTGOMERY AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town ROCKVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D 4
(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME Franklin G. Carlin

3. (b) Social Security Number 212-24-4198

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single.

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JANUARY 5TH 1929

8. AGE: Years	Months	Days	If less than one day
16	5	20	..... hrs. ..... min.

9. Birthplace ROCKVILLE, MD.
(Town, county, and state)

10. Usual occupation STUDENT

11. Industry or business —

FATHER 12. Name FRANCIS G. CARLIN

13. Birthplace MARYLAND.

MOTHER 14. Maiden name PEARL KING.

15. Birthplace MARYLAND.

16. Informant MRS PEARL J. WARD.

Address ROCKVILLE MD RFD 4.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-27-45 (month) (day) (year)

Cemetery or ~~crematory~~ M. E. CHURCH CEMETERY

Location HYATTSTOWN MARYLAND

18. Funeral director Warner E. Pumphrey.

Address 8434 GA. AVE, SILVER SPRING, MD.

19. 6/26/45 (Date rec'd by registrar) 19 Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 1:18 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam Care 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Hemorrhage	Killed instantly
Due to Severance of Rt. Jugular Vein	
Due to Fracture of skull (accidental)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-25-45

Where did injury occur? Rockville (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Street

Means of injury auto accident Injured at work? no

23. SIGNATURE Fred J. Brashear M.D.
Dep. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 6-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

6173

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newboro infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Carrie Lee Verney Carroll

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): April, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	7	...hrs. ...min.

9. Birthplace: Cooksville, Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER

12. Name: Nimrod Dorsey

13. Birthplace: Carroll City, Maryland

MOTHER

14. Maiden name: Sara Kline

15. Birthplace: Frederich Co., Maryland

16. Informant: Hospital Records

Address: Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/18/45 (month) (day) (year)

Cemetery or crematory: Harmony Cemetery

Location: Near Finksburg Md.

18. Funeral director: D. L. Gaither

Address: Gaithersburg Md.

19. June 17 1945 (Date rec'd by registrar) Arnold L. Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June - 16 - 1945 at 5:45 A M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from May - 27 1945, to June - 16 - 1945, and that I last saw her alive on June - 15 - 1945

Immediate cause of death	DURATION
Acute Pulmonary & Intestinal Cerebral Hemorrhage	19 days
Due to: Senility	—
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Acute pulmonary embolism

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: William C. Miller, MD (M. D. or other)

Address: Gaithersburg, Md. Date signed 6/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

06174

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery Co. Md

City or town 4706 Crescent St. N. W.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Ft Massachusetts Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4706 Crescent St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME DOROTHY V. CARTER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Herbert M. Carter

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29 1886

8. AGE: Years 59 | Months 6 | Days 16 | If less than one day ____ hrs. ____ min.

9. Birthplace Leesburg Va

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Unknown Wright

13. Birthplace Va

MOTHER 14. Maiden name Ella Harper

15. Birthplace Va

16. Informant Dorothy M. Gearhart

Address 4706 Crescent St. N.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6 15 45 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W. W. Chambers Co.

Address 1400 Chapin St. N.W.

19. 6/15 19 45 Wm E Jackson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945, to June 15 1945 and that I last saw h alive on June 13 1945.

	DURATION
Immediate cause of death Cerebral hemorrhage	Immediate
Due to Hypertension	5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 3330 14th St. N.W. Date signed 6/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-G)

06175

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County MONTGOMERY

City or town TAKOMA PARK, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
WASHINGTON SANITARIUM

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGES

City or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 ALLEGHENY AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FRANCES COLFORD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	

6.(b) Name of husband or wife CLARENCE SMITH (COMMON LAW HUSBAND)

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) MAY 31 1914

8. AGE: Years	Months	Days	If less than one day
31		4	....hrs. ....min.

9. Birthplace PITTSBURGH, PENNA.
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name JAMES COLFORD
13. Birthplace PITTSBURGH, PENNA.

MOTHER
14. Maiden name
15. Birthplace IRELAND

16. Informant CLARENCE SMITH
Address

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) 6 (day) 4 (year) 45

Cemetery or crematory

Location Harrington, DE

18. Funeral director Martin W. Hysong & Co.

Address 1300 - N St. N.W.

19. (Date rec'd by registrar) June 4 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1945, at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3, 1945, to June 4, 1945 and that I last saw h.er alive on June 4, 1945

Immediate cause of death	DURATION
Acute Hepatitis	two days?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul V. Starr, M.D. (M. D. or other)

Address Takoma Park, Md. Date signed 6-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

FILM No. G 96 JUL 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

06176

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery Co.

City or town Takoma P.R. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Takoma P.R. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 802 Jackson ave Takmd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Loring Guild Conger

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Col Arthur L Conger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8. 1866

8. AGE: Years	Months	Days	If less than one day
78	yy.		..... hrs. ..... min.

9. Birthplace Mass (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George A Guild

13. Birthplace Mass

MOTHER 14. Maiden name Harriett E Rice

15. Birthplace Mass.

16. Informant Col Arthur L Conger

Address 802 Jackson ave Takoma P.R.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 7. 1945 (month) (day) (year)

Cemetery or crematory Cremation Lee Funeral Home

Location 3004 4th St N.E. Wash D.C.

18. Funeral director J. Wm Lee sons Co.

Address 3004 4th St N.E.

19. June 9 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.30, to June 4 1945

and that I last saw h.e.r. alive on June 4 1945

Immediate cause of death	DURATION
CARDIAC DILATATION	1 hour
Due to	
Due to	
Other conditions CEREBRAL HEMORRHAGE	4 yrs
general debility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm A Thomson M.D
M. D. or other

Address 113 Carroll St. N.W. Tak. P.K. Md. Date signed June 9. 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

06177 Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since birth (58 yrs)
Hospital, institution, or street address where death occurred:
Wash. Sanitarium & Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 810 Flower Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Conine, Grace Estelle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Separated

6.(b) Name of husband ~~or wife~~ Charles Conine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1- 1887

8. AGE: Years	Months	Days	If less than one day
58	—	—	..... hrs. ..... min.

9. Birthplace Takoma Park, Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name James Collins
13. Birthplace Montgomery Co., Md

MOTHER
14. Maiden name Martha Giddings
15. Birthplace Montgomery Co., Md.

16. Informant Son (Mr. Charles Conine)
Address 810 Flower Ave. Tak. Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 1945 (month) (day) (year)

Cemetery or crematory George Washington Memorial

Location Prince Georges Co.

18. Funeral director Warner & Pumphrey.

Address 8434 Ga Ave Silver Spring. Md

19. June 2 1945 (Date rec'd by registrar) J. D. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1- 1945, at 2:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1945, to June 1- 1945
and that I last saw her alive on June 1- 1945

	DURATION
Immediate cause of death old & recent myocardial infarcts	6 months
Due to Arterio - sclerosis	10 years
Due to cardiac failure.	
Other conditions Generalized anasarca	6 months

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of Autopsy 6/1/45

Autopsy results as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. E. Shoemaker M.D. M. D. or other
Address 8005 Woodbury Drive Silver Spring, Md Date signed 6/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

06178

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 51 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4605 Glenbrook Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frederick H. Carwin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W.	married

6.(b) Name of husband or wife Maude W. Carwin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	18	hrs. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual occupation retired
11. Industry or business
FATHER 12. Name Milton M. Carwin
13. Birthplace N. Y.
MOTHER 14. Maiden name Spear
15. Birthplace Vermont
19. Informant Hospital Records
Address Suburban Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/12/45 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem.
Location Maryland
18. Funeral director Wm Reuben Pumphrey
Address 7557 Wis. Ave. Bethesda
19. 6/12 1945 Wm E Jacobs Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945 at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/20/45 1945, to 6/9/45 1945
and that I last saw h alive on 1945

Immediate cause of death	DURATION
Lobar Pneumonia	
Right Lower Lobe - Confluent	
Lobular Pneumonia Left Lower Lobe	
Due to	
Due to Accidental falls. C.W.S.R.	
Other conditions Fracture of Neck of Left Femur.	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results See Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of April 13, 1945.
Where did injury occur? Bethesda (City or town) Montgomery (County) Maryland (State)
Injured at home, farm, industry, public place (where?)
Means of injury Accidental fall Injured at work?

23. SIGNATURE Richard E. Kelso, M. D.
M. D. or other
Address Suburban Hosp. Bethesda Md. Date signed 6-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

06179

File No. G96 JUN 25 1945

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred: 4845 Del Ray Ave. Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty.

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4845 Del Ray Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lena Minnie Counselman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Benjamen S.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 7, 1859

8. AGE: Years	Months	Days	If less than one day
86 85			..... hrs. ..... min.

9. Birthplace: N. Y. State (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Bernard Scherer

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Mary Scheper

MOTHER — 15. Birthplace: Germany

16. Informant: Clarence Gilbert

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/16/45 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem

Location: Rockville, Md.

18. Funeral director: Wm. Reuben Dunphrey

Address: Bethesda, Md.

19. 6/15 1945 (Date rec'd by registrar) Wm. E. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14, 1945, at 5:46 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945, to June 14 1945, and that I last saw h[illegible] alive on June 13 1945

Immediate cause of death	DURATION
Senility - Old Age	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M.D.

M. D. or other

Address: [illegible] Date signed 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06181 213 – Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Potomac, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Potomac, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
~~State~~ D.C. County
City or town: Wash. D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3224 Wis. Ave. N.W. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nathan T. Dove

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Viva Denton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66				

9. Birthplace: Potomac, Md (Town, county, and state)
10. Usual occupation: Guard
11. Industry or business:
FATHER 12. Name: William Thomas Dove
13. Birthplace: Maryland
MOTHER 14. Maiden name: Hoover
15. Birthplace: Maryland
16. Informant: Mrs. Viva D. Dove
Address: 3224 Wis Ave. N.W. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/28/45 (month) (day) (year)
Cemetery or crematory: Potomac Cem.
Location: Potomac, Md.
18. Funeral director: Wm Reuben Pumphrey
Address: Rockville, Md.
19. 6/26/45 (Date rec'd by registrar) Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 19 45 at 9:00 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 31 to June 25 19 45
and that I last saw h alive on 19
Immediate cause of death: Coronary occlusion — DURATION: died suddenly
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broccard M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed 6-25-45

Evidence for addition of color is shown on

FILM No. G 97 JUL 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

06180

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County:
City or town: Miami
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1449 SW 4th St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George Alfred DURRANT, Jr. AMM3c V-6 USNR Active

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Wife: Mary E. Durrant
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 16, 1906

8. AGE: Years	Months	Days	If less than one day
38	5	23	..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: George A. Durrant
13. Birthplace: New York City

MOTHER
14. Maiden name: Catherine C. Meaney
15. Birthplace: New York City

16. Informant: Wife: Mrs. Mary E. Durrant
Address: 1449 SW 4th St., Miami, Florida

17. removal (Burial, cremation, or removal. Which?) Date thereof 6-9-45 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Miami, Florida
18. Funeral director: W. W. Chambers W.D.C.
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 6-9- 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 June 1945, at 8:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 May 1945, to 9 June 1945 and that I last saw h... in alive on 9 June 1945

Immediate cause of death	DURATION
(a) CEREBRAL HEMORRHAGE	1 HOUR
Due to LEUKEMIA, ACUTE	5 Weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A. B. Hayles Lt. A. B. Hayles, (MC) USN M. D. or other
Address: USNH Bethesda, Md. Date signed 6-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

06182

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium Hosp.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Randolph Place, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Rose Eberly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 9, 1875

8. AGE: Years	Months	Days	If less than one day
70	5	8	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home

FATHER 12. Name John A. Buechler

13. Birthplace Germany

MOTHER 14. Maiden name Mary A. Wambold

15. Birthplace Germany

16. Informant Rhoda Wash., Sam. Hosp.

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19, 1945 (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Washington D.C.

18. Funeral director J.H. Hinks Co

Address 2901 - 14th St. N.W.

19. Jun 17 1945 (Date rec'd by registrar) J.H. Hinks Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5. 1945, to June 17 1945; and that I last saw h... alive on June 16 - 1945

Immediate cause of death	DURATION
Coronary Occlusion	6 hrs
Due to Hypertension Cardio-Vascular Disease	3 yrs
Due to Arteriosclerosis	
Other conditions -	

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury Injured at work?

23. SIGNATURE Henry S. Brown M.D. M. D. or other

Address Takoma Park Md Date signed 6/17/45

06183

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Diat. No. 213-

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 17 West Wood Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Edmonds

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 15 1874

8. AGE: Years: 70 | Months: 11 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Frederick County, Md. (Town, county, and state)

10. Usual occupation: House keeper

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Charles Edmonds (Son)
Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18, 1945 (month) (day) (year)
Cemetery or crematory: Arlington Nat. Cemetery
Location: Washington D. C.

16. Funeral director: Robert L. Saunders
Address: 246 N. Wash. St. Rockville, Md.

19. 6/17-45 (Date rec'd by registrar) 19 Josephine S. Hostton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 19 45, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 45, to June 13 19 45
and that I last saw her alive on June 12 19 45

Immediate cause of death	DURATION
Lobar Pneumonia	6 D.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. W. Webb M. D. or other
Address: Rockville, Date signed: 6/16/45

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

06184

Reg. Diat. No. 213.

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Westmore, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Westmore
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: HARVEY REID ETCHISON

3.(b) Social Security Number: 217-01-7260

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Divorced

6.(b) Name of husband or wife: Edith M. Bennett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 23rd. 1886

8. AGE: Years	Months	Days	If less than one day
59	3	18	hrs. min.

9. Birthplace: Clarksburg, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Glen Echo
FATHER 12. Name: Bradley S. Etchison
FATHER 13. Birthplace: Damascus, Md.
MOTHER 14. Maiden name: Ella M. Warfield
MOTHER 15. Birthplace: Damascus, Md.
16. Informant: Mrs. Mary Gossard
Address: Rockville, Rt. 4 Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/14/45 (month) (day) (year)
Cemetery or crematory: xxxxx Clarksburg
Location: Clarksburg, Md.
16. Funeral director: Warner E. Pumphrey
Address: Rockville, Md.
19. 6/13 (Date rec'd by registrar) HS-Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945, at 6:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brouchart M.D. Att. Phy. Exam M. D. or other
Address: Gaithersburg Md. Date signed 6-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (460 R)

06185

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 YEAR
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4801 CHEVY CHASE DRIVE
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: BLANCHE A. FARRELL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APRIL 5, 1880

8. AGE: Years: 65 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: OLD TOWN MAINE (Town, county, and state)

10. Usual occupation: MAIL TELLER

11. Industry or business: NATIONAL METROPOLITAN BANK

FATHER
12. Name: JOHN FARRELL
13. Birthplace: IRELAND

MOTHER
14. Maiden name: ABBIE MURPHY
15. Birthplace: BANGOR, MAINE

16. Informant: MARY E. FARRELL
Address: 4801 CHEVY CHASE DR, CH. CH. MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 7-4-1945 (month) (day) (year)
Cemetery or crematory: MT. PLEASANT
Location: BANGOR, MAINE

18. Funeral director: Joseph Gawler's Sons Inc.
Address: 1756 Pa. Ave, N.W. Wash, D.C.

19. 6-30-45 19 ... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-28 19 45 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 19 45 to June 28 19 45 and that I last saw h... C.R. alive on June 28, 19 45

	DURATION
Immediate cause of death: Gen. Carcinomatosis	
Pleural Effusion	4 mos
Due to: Metastatic Carcinoma	6 mos
Due to: Primary Cystadenoma	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Metastatic Ca. of Ovary
Colon Date of op. 4/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Benedict Miller M. D. or other
Address: 1028 Conn Ave Date signed: 6-30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 3 1965

06186

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs - Mattie Fisher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 10, 1877

8. AGE:

Years	Months	Days	If less than one day
68	2	14	hrs. min.

9. Birthplace: Rockville, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Thomas Connolly

13. Birthplace

MOTHER

14. Maiden name: Annie F. Kissa

15. Birthplace: Frederick, Md.

16. Informant: Mrs. Joseph Matthews - daughter

Address: Edson Lane, Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27, 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: W. W. Chamberlin Co.

Address: 3072 - M St. N.W.

19. 6/24 1945 (Date rec'd by registrar) Wm E Jobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24, 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943, to June 24 1945

and that I last saw h[illegible] alive on June 24 1945

Immediate cause of death	DURATION
Cerebral Embolism	1 day
Due to: Hypertension & Arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed 6/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

CERTIFICATE OF DEATH

★ 06187

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montg
City or town Gaithersburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? accident
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montg
City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Elizabeth Fletcher.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	white	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) apr 14 1925

8. AGE:	Years	Months	Days	If less than one day
1925	20	2	9	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Stenographer
11. Industry or business
FATHER 12. Name George Clide Fletcher
13. Birthplace ~~Md~~ Pa.
MOTHER 14. Maiden name Anna Frances Small
15. Birthplace Md
16. Informant George C. Fletcher
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/26/45 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg Md
18. Funeral director C. C. Gartrell
Address Gaithersburg Md
19. June 25 1945 Alexander G. Cooke Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/23/ 1945 at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fracture of 3rd cervical Vertebra with injury to spinal cord	
Due to Intra cranial Hemorrhages	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 6/23/45
Where did injury occur? Gaithersburg (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?) Road
Means of injury Automobile Accident Injured at work?

23. SIGNATURE [signature] Approx Published M. D. or other
Address Gaithersburg Md Date signed 6/23/45

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-9)

CERTIFICATE OF DEATH

66188

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

8708 Colesville Rd. Apt. 301

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8708 Colesville Road.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: ALAN PALMER FURPHY

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22nd. 1943

8. AGE: Years	Months	Days	If less than one day
2	1	27	hrs. min.

9. Birthplace: Elmira, N. Y.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Foster LeRoy Furphy

13. Birthplace: Brooklyn, N. Y.

MOTHER — 14. Maiden name: Grace Palmer

15. Birthplace: East Creek, N. Y.

16. Informant: Col. Foster LeRoy Furphy

Address: 8708 Colesville Rd.

17. cremation (Burial, cremation, or removal. Which?) Date thereof: 6/19/45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Prince Georges Co. Md.

18. Funeral director: Frances Dempsey

Address: 8434 Ga. Ave. Silver Spring. Md.

19. June 19 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1945 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19, 1945 to June 19, 1945 and that I last saw h... alive on June 19, 1945

Immediate cause of death	DURATION
Atresia of bile ducts, congenital.	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis E. Lieder

Louis E. Lieder, Lt. Col. MC M. D. or other

Address: WRGH, AMC, Wash. D.C. Date signed: 19 June 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

T

06189

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 3 hours 55 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Blandy Cabins

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Infant Girl Briggs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Newborn

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 4, 1945

8. AGE:

Years	Months	Days	If less than one day
			3 hrs. 55 min.

9. Birthplace Bethesda Montgomery, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Carroll Lawrence Briggs

13. Birthplace Arlington Texas

MOTHER

14. Maiden name Margie Inez Tidwell

15. Birthplace Spiro, Oklahoma

16. Informant

Address

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 6/6 1945 Mrs E Jobes Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1945, at 2:30a M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 4, 1945 to June 5, 1945 and that I last saw her alive on June 5, 1945

Immediate cause of death	DURATION
Premature 5 mo.	
Due to	
Due to Cause Unknown	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Otto F. Engelhardt M.D.

M. D. or other

Address Suburban Hosp. Date signed 6/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-a)

CERTIFICATE OF DEATH

06199

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Bethesda — Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington County: D. C.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4702 - Winden Pl N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Gurney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband ~~or wife~~: Charles Gurney
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec - 3 - 1865

8. AGE: Years	Months	Days	If less than one day
79	6	14	hrs. min.

9. Birthplace: Rochester — N-Y
(Town, county, and state)

10. Usual occupation: X

11. Industry or business

FATHER
12. Name: William Dorsey
13. Birthplace: N-Y.

MOTHER
14. Maiden name: Elizabeth Bingham
15. Birthplace: N-Y.

16. Informant: Chas. Gurney
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 18 - 1945 (month) (day) (year)
Cemetery or crematory: COLDWATER Michigan
Location:

18. Funeral director: Martin W. Hyson Co.
Address: 1300 - N. St. N.W. Wash. 5, D.C.

19. 6/17 1945 (Date rec'd by registrar) Wm E Jeffers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.. alive on ..... 19.....

Immediate cause of death	DURATION
Abdominal Carcinoma —	
Widespread peritoneal implants	
Due to: Primary Ovarian Carcinoma	
Due to:	
Other conditions: Ascites, Pulmonary Infarction	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: See Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Richard E. Kelso M.D.
M. D. or other
Address: Bethesda, Md Date signed: 6-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

8012 - Georgetown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06191

Reg. Dist. No. 218

1. PLACE OF DEATH
County Montgomery
City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gertrude Hackett

3.(b) Social Security Number

4. Sex female
5. Color or race colored
6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife Eugene Hackett
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 58 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace Poolesville Md
(Town, county, and state)
10. Usual occupation House - keeping
11. Industry or business at home & as domestic
FATHER 12. Name William Oxley
13. Birthplace unknown
MOTHER 14. Maiden name Mary Hill
15. Birthplace unknown
16. Informant Jennie Ivory
Address Beallsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23, 1945 (month) (day) (year)
Cemetery or crematory Mt. Zion Cemetery
Location Barnesville, Md.
18. Funeral director R. L. Snouffer
Address 246 N. Wash. St. Rockville, Md
19. June 23 1945 Rhoda L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 20 - 1945, at 12-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1942 to June - 20 - 1945 and that I last saw h. on alive on June - 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William E. Miller M.D. M. D. or other

Address Gaithersburg, Md. Date signed 6/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. I 00 JAN 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06192 ★ Reg. Dist. No. 211

1. PLACE OF DEATH:
County Montgomery Co
City or town Cedar Grove (If outside city or town limits, write RURAL and give nearest town) Rural
How long in above place of death? 14 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Montgomery Co
City or town Cedar Grove (If outside city or town limits, write RURAL and give nearest town) Rural
Street No. Germantown Md (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Jackson Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Mal	W	Widowed

6.(b) Name of husband or wife Unknown dead
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 6 - 1883

8. AGE: Years	Months	Days	If less than one day
60 59	9	24	hrs. min.

9. Birthplace Va (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Charles Hall
13. Birthplace Va
MOTHER 14. Maiden name Unknown
15. Birthplace Md
16. Informant Myrtle Pugh
Address Germantown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 1945 (month) (day) (year)
Cemetery or crematory Laytonsville Cem
Location Montgomery Co Md
18. Funeral director Roy W Barber
Address Laytonsville Md
19. June 2 1945 Della N. Burdette (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1945 at 6:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1942, to June 30 1945 and that I last saw him alive on May 28, 1945
Immediate cause of death Arteriosclerotic cardiovascular disease — DURATION 10 years
Due to Cerebral Hemorrhage, Hemiplegia right side — DURATION 7 years
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F. Kerr M.D. M. D. or other
Address Damascus, Md. Date signed 6/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 9618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Rural Cedar Grove mn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rural Cedar Grove mn
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Mamie Estell Hawkins

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife Joseph F. Hawkins
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov 6 - 1875

8. AGE: Years	Months	Days	If less than one day
69	6	27	...hrs. ...min.

9. Birthplace Montgomery Co Md
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business Home
FATHER 12. Name Henery Tyler
FATHER 13. Birthplace Montgomery Co Md
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown
16. Informant Lester Hawkins
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 5 1945 (month) (day) (year)
Cemetery or crematory Pleasant Grove Cem
Location Montgomery Co Md
18. Funeral director R. W. Barber
Address Gaithersburg Md
19. 6/4/45 (Date rec'd by registrar) L. D. Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 6 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1945 to June 1 1945 and that I last saw h... alive on June 1 1945

Immediate cause of death	DURATION
Myocardial degeneration	
Due to —	
Due to —	
Other conditions Bronchial asthma	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Barry Stanley M.D.
M. D. or other
Address Gaithersburg Md Date signed June 4, 1945

06194

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7924 Wisconsin Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carol Hetrick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16, 1945

8. AGE: Years	Months	Days	If less than one day
	3	14	..... hrs. ..... min.

9. Birthplace Bethesda, Montgomery, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Timothy J. Hetrick
13. Birthplace DuBois, Pennsylvania

MOTHER
14. Maiden name Florence Skinner
15. Birthplace DuBois, Pa.

16. Informant Hospt. Records

Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 7/2/45 (month) (day) (year)

Cemetery or crematory Rockville Union Cem

Location Rockville, Md.

18. Funeral director Wm Reuben Pennybacker

Address 7557 Wis. Ave Bethesda

19. 7/2 1945 Wm E Jolley Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 5:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1945, to June 30 1945

and that I last saw him E.R. alive on ..... 19.....

Immediate cause of death	DURATION
Broncho-pneumonia	3 Days
Due to congenital Heart Disease	Life
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold W. Hobart M.D.
M. D. or other

Address 5402 Conn ave Date signed 6/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06195

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Monty

City or town: Chevy Chase Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs

Hospital, institution, or street address where death occurred:

321 W. Bradley La.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 W. Bradley La.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert J. Hoage

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Gertrude B.

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): June 27, 1877

8. AGE:

Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: Iowa (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: James Alvin Hoage

13. Birthplace: N. Y.

MOTHER 14. Maiden name: Lizzie Stewart

15. Birthplace: Ind.

16. Informant: Alden Hoage

Address: 3826 Windom Pl. N. W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/5/45 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location: Wash. D.C.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 6/5 1945 (Date rec'd by registrar) Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 19 45 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam Case to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.

Dep. Med. Exam M. D. or other

Address: Gaithersburg Md. Date signed 6-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46) X

06196

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Colesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Colesville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Colesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: On Pike in Colesville
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: CHARLES ALPHEUS HOBBS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife: Alice Naomi
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 28th. 1887

8. AGE: Years	Months	Days	If less than one day
58	4	20	..... hrs. ..... min.

9. Birthplace: Howard Co., Md. (Town, county, and state) route
10. Usual occupation: owner & operator of Milk
11. Industry or business
FATHER 12. Name: Franklin Marion Hobbs
13. Birthplace: Sunshine, Md.
MOTHER 14. Maiden name: Martha Eliz. Johnson
15. Birthplace: Howard Co. Md.
16. Informant: Mrs. Alice Naomi Hobbs
Address: Colesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/20/45 (month) (day) (year)
Cemetery or crematory: Colesville
Location: Colesville, Montg. Co. Md.
18. Funeral director: Wames E Pumphrey
Address: 8434 Ga. Ave. Silver Spring. Md.
19. June 19 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1945, at 12 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945, to June 18 1945 and that I last saw h~~im~~ alive on June 17 1945

Immediate cause of death	DURATION
Cancer (Carcinoma) of Stomach	4 Mo. 6 Da.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Johns Hopkins Univ. Confirmed diagnosis Date of op. 3-9-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Mason Blackhead - M.D. Per Committee M.D., or other
Address: Silver Spring, Md. Date signed: 6-19-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-M)

06197

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Monty
City or town Brookdale md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo. 1 day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Monty
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Mason Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jean Locke Hubbell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Albert C Hubbell
6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Mar 25 1911

8. AGE: Years	Months	Days	If less than one day
34	2	18	hrs. min.

9. Birthplace Morristown Tenn.
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business -

FATHER
12. Name Arch Baylor
13. Birthplace Va

MOTHER
14. Maiden name Nellie Ault
15. Birthplace Somerville Tenn.

16. Informant Nellie Locke
Address 5200 Murray Rd. Brookdale md

17. (Burial, cremation, or removal. Which?) Removal, Wash., D.C. Date thereof (month) (day) (year)
Cemetery or crematory
Location
16. Funeral director J. William Levy Sons
Address 308 - 4½ St. N.E.

19. 6/13 1945 (Date rec'd by registrar) Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac insufficiency	Instd.
Due to Found dead in auto.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 6-13-45
Where did injury occur? Brookdale (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchant M.D.
Dep. Med. Exam M. D. or other
Address Gaithersburg md Date signed 6-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06198

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Monty

City or town: Brookdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Monty

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Manor Circle

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Philip Barry Hubbell

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 30 1939

8. AGE:	Years	Months	Days	If less than one day
	6	2	13	..... hrs. ..... min.

9. Birthplace Wash. DC. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name Albert C Hubbell

13. Birthplace Va

MOTHER

14. Maiden name Jean Baylor

15. Birthplace Thornstown, Tenn.

16. Informant Nellie Locke

Address 5200 Murray Rd. Brookdale Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Removal, Md, DC

Location

18. Funeral director J. William Leis Sons

Address 300 - 4th St. NE

19. 6/13 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam case 19.. to ..... 19..

and that I last saw h..... alive on ..... 19..

	DURATION
Immediate cause of death: Carbon Monoxide Poisoning (Homicide)	Instantaneous dead
Due to: Found dead in automobile	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 6-13-45

Where did injury occur? Brookdale (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bromberg M.D.

Dep. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 6-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06199

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State N.Y. County Westchester
City or town Standale Scarsdale N.Y.B.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 93 Green Acres Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Frederick Hudson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Virginia Hudson
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29 1901

8. AGE: Years	Months	Days	If less than one day
43	5	19	hrs. min.

8. Birthplace Cincinnati Ohio
(Town, county, and state)
10. Usual occupation Am. Tel. Co.
11. Industry or business
FATHER 12. Name Samuel Hudson
13. Birthplace Ohio
MOTHER 14. Maiden name Eliz. McNeal
15. Birthplace Ohio
16. Informant Mrs Ralph Hudson
Address 2715 Dayton Rd. Chevy Chase Md
17. Removal to (Burial, cremation, or removal. Which?) Date thereof 6/18/45 (month) (day) (year)
Cemetery or crematory Nash. D.C.
Location
18. Funeral director Jos. Gawler's Sons
Address Nash. D.C.
19. 6/18 19 45 Wm E Jobes (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945, at 1:10 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brockhaut M.D. M. D. or other
Address Gaithersburg Md Date signed 6-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06200

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RUKAL and give nearest town)
How long in above place of death? Two months
Hospital, Institution, or street address where death occurred:
310 Hancock Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 310 Hancock Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Norma Evelyn Hull

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas Smith Hull
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 9, 1889

8. AGE: Years	Months	Days	If less than one day
56	0	0	hrs. min.

9. Birthplace: Braddock, Pa. (Town, county, and state)
10. Usual occupation: House keeper
11. Industry or business: Homes
FATHER 12. Name: Ellis B. Landman
13. Birthplace: —
MOTHER 14. Maiden name: Mary E. Smith
15. Birthplace: —
16. Informant: George Smith Hull
Address: 310 Hancock Ave., Takoma Pk. Md.
17. (Burial, cremation, or removal. Which?) Date thereof: June 12, 1945 (month) (day) (year)
Cemetery or crematory: Geo. Wash. Memorial Park
Location: Riggs Road, Hyattsville, Md. Prince Geo. Co.
18. Funeral director: Arthur Walters.
Address: 754 Carroll St. N.W.
19. June 10, 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9, 1945 at 11 05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1945 to June 7, 1945
and that I last saw her alive on May 27, 1945

	DURATION
Immediate cause of death: Coronary occlusion	15 days
Due to: Coronary heart disease	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wallace H. Mook M.D.
M.D. or other
Address: 805 Carroll Ave., Takoma Park, 12, Md. Date signed: 6-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06201

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Wheaton Md. P
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wheaton Md.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Bryon Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

8.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 83 ? | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Aldie VA
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name unk.
13. Birthplace

MOTHER
14. Maiden name Pernila Jackson
15. Birthplace unk

16. Informant Sudie Lee
Address Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4, 1945 (month) (day) (year)
Cemetery or crematory Middleburg Va
Location Washington D.C.

18. Funeral director Valley Funeral
Address 9137 16th. Ave. NW

19. June 1 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May ? 1944 to June 1 1945
and that I last saw h[illegible] alive on May 28 1945

Immediate cause of death	DURATION
Chronic Nephritis	2 yrs
Due to	
Due to	
Other conditions Chronic Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Calvin B. LeCompte M. D. or other
Address Wheaton Md Date signed 6/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No. G96 JUN 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

06202

Reg. Dist. No. 723

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Takoma Park
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 216 Ethan Allen Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: Wood War #1

3.(a) FULL NAME: Alfred Jacobs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Wilma K Jacobs
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 19 1886

8. AGE: Years	Months	Days	If less than one day
59	2	1	..... hrs. ..... min.

9. Birthplace: N.Y. City (Town, county, and state)
10. Usual occupation: Medical Research
11. Industry or business

MOTHER
12. Name: Gustave Jacobs
13. Birthplace: Germany

FATHER
14. Maiden name: Jennie Hecht
15. Birthplace: Germany

16. Informant: Teresa C. Ehlen
Address: 1023 14th St N. Arlington Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 1945 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Adel Funeral Home
Address: 4812 Ga. Ave. N.W. Wash. D.C.

19. June 21 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 19 45 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 .. to .. 19 .. and that I last saw h .. alive on .. 19 ..

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D.
Dep. Med. Exam M. D. or other
Address: Frederick, Md. Date signed 6-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

06203

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH

County: Monty

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr

Hospital, Institution, or street address where death occurred: Suburban Hosp.

How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Rural Poolesville Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Basil Edward Jenkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Resetta Jenkins

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Dec 1 1894

8. AGE: Years	Months	Days	If less than one day
50	6	27	hrs. min.

9. Birthplace: Montgomery Co (Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER — 12. Name: William Jenkins

13. Birthplace: Prince George Co

MOTHER — 14. Maiden name: Annie Stovid

15. Birthplace: Montgomery Co

16. Informant: Resetta Jenkins

Address: Poolesville md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2 1945 (month) (day) (year)

Cemetery or crematory: Martinsburg

Location: near Dickerson

18. Funeral director: Clarence H Davis

Address: Poolesville Md

19. 7-2-45 (Date rec'd by registrar) 19.. N E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 19 45, at 4:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept Med Exam 19.., to date 19..

and that I last saw h.. alive on .. 19..

Immediate cause of death	DURATION
Acute Cardiac dilatation	2 hrs
Due to: Chronic Myocarditis	Indefinite
Due to:	
Other condillons	

(Includo pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed 6-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06204

Reg. Dist. No. 212

1. PLACE OF DEATH:
County: Monty
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: Adelia L. Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widow

6.(b) Name of husband or wife: John R. Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 10 1874

8. AGE: Years	Months	Days	If less than one day
71	2	9	..... hrs. ..... min.

9. Birthplace: Monty Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: John Heffner
13. Birthplace: Md.
MOTHER — 14. Maiden name: Martha Trundle
15. Birthplace: Md.
16. Informant: Francis L. Jones
Address: Clarksburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-22-45 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville Md.
18. Funeral director: Wm. B. Hilton
Address: Barnesville, Md.
19. June 19 1945 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W. B. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1945 at 6:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2nd Prof Exam. Case to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Some days in bed
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

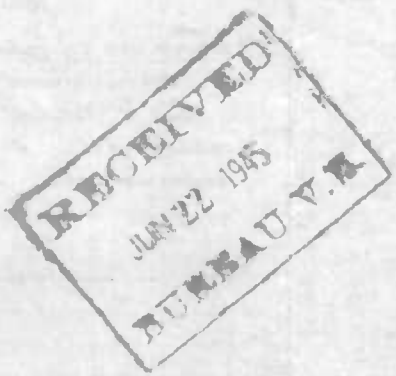
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph J. Brochart M.D.
M. D. or other
Address: Prof. Med. Exam. Frostburg, Md. Date signed 6-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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JUN 22 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-a)

CERTIFICATE OF DEATH

T 06205

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother) mont
State: County:
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7304 Wilmington Terr.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Infant Boy Kennedy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	newborn

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 5, 1945

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Bethesda Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Frank Walter Kennedy
13. Birthplace: Boston, Mass.

MOTHER
14. Maiden name: Margaret Mary Ross
15. Birthplace: Boston, Mass.

16. Informant
Address

17. Laboratory (Burial, cremation, or removal. Which?) Date thereof 6/5/45 (month) (day) (year)

Cemetery or crematory
Location

18. Funeral director
Address

19. 6/11/45 19 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/6 1945 at 10:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19
Immediate cause of death: Hydrocephalus — DURATION

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J D Donovan M.D.
M. D. or other
Address: 810 Quincy St Date signed 6/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06206

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-2) L

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5309 - 13th Street, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Klinge, Mr. Charles Otto

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) February 23, 1873

8. AGE: Years	Months	Days	If less than one day
72	4	6	____ hrs. ____ min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual occupation Retired Contractor
11. Industry or business

FATHER
12. Name Henry Klinge
13. Birthplace ? Germany

MOTHER
14. Maiden name Katherine Trushein
15. Birthplace ? Germany

16. Informant Washington San. & Hospital Records
Address Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July-2-45 (month) (day) (year)
Cemetery or crematory Rock Creek Cem. Wash.-D.C.
Location Washington-D.C.
18. Funeral director Deal Funeral Home
Address 4812-Georgia-Ave-N.W.
19. June 30 1945 (Date rec'd by registrar) J. Holmes Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 7 33 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945 to June 29 1945
and that I last saw him alive on June 29, 1945

Immediate cause of death	DURATION
Bronchopneumonia terminal	
Due to Suppurative Bronchiectasis chronic	
Due to Carcinoma of descending colon c metastasis to liver	
Other conditions Gen. arteriosclerosis with coronary sclerosis	

(Include pregnancy within 3 months of death)
Major findings of operation Carcinoma of descending colon; diverticulosis
Date of op. June 26, 1945
Autopsy results as noted above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lloyd H. Calver M.D.
M. D. or other
Address 894 Pa Ave, S.E. Date signed 6-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-E)

CERTIFICATE OF DEATH

#16207

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: BETHESDA (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 YEARS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: BETHESDA (If outside city or town limits, write RURAL and give nearest town)
Street No. 4517 - EAST-WEST HIGHWAY (If rural, give LOCATION)
2.(a) 11 veteran, name war: No

3. (a) FULL NAME: REV. JOSEPH A. WITTLE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APRIL 4, 1879

8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.

9. Birthplace: PENN (Town, county, and state)

10. Usual occupation: CATHOLIC PRIEST

11. Industry or business

FATHER
12. Name: AUGUSTUS WITTLE
13. Birthplace: PENN

MOTHER
14. Maiden name: MATILDE SNEERINGER
15. Birthplace: PENN

16. Informant: CORINNE WITTLE
Address: PENN

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 6-11-45 (month) (day) (year)
Cemetery or crematory: St Joseph's Cemetery
Location: Bonnerville Penn
18. Funeral director: Francis J Collins
Address: 3821-14 th St. NW. Wash. D.C.
19. 6/7 19 45 (Date rec'd by registrar) Mrs E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 19 45 at 3 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27th 19 45 to June 7 19 45 and that I last saw him alive on May 29 19 45

Immediate cause of death	DURATION
Respiratory failure	
Due to: Cerebral Thrombus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Jaggers M.D. M. D. or other
Address: 8016 Georgetown Rd. Date signed: 6/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06208

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-20)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 29 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 2 months 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County:

City or town: Mineral Point
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MILLER, William Robert, CCS V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Sara Miller

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 4, 1902

8. AGE: Years	Months	Days	If less than one day
42	7	18	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: Robert (n) Miller
13. Birthplace: Scotland

MOTHER — 14. Maiden name: Alice Egleston
15. Birthplace: England

16. Informant: Wife: Mrs. Sara Miller
Address: Mineral Point, Pennsylvania

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 23, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Johnstown, Pennsylvania

18. Funeral director: W. W. CHambers
Address: 1400 Chapin St., N.W., Washington, D.C.

19. 22 June 1945 (Date rec'd by registrar)

Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 June 1945, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 March 1945, to 22 June 1945, and that I last saw h[illegible] alive on 22 June 1945

Immediate cause of death	DURATION
Carcinoma Lung	Indefinite
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: confirmed clinical dia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: U.S.N.H. Bethesda Md. Date signed: 6-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

062 09

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:

912 SILVER SPRING AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: SILVER SPRING.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 912 - SILVER SPRING AVE

(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME: James J. Mullarkey

3. (b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): UNKNOWN.

8. AGE: Years	Months	Days	If less than one day
68	—	—	hrs. min.

9. Birthplace: IRELAND (Town, county, and state)

10. Usual occupation: COOK

11. Industry or business

FATHER — 12. Name: UNKNOWN.

FATHER — 13. Birthplace: IRELAND

MOTHER — 14. Maiden name: UNKNOWN.

MOTHER — 15. Birthplace: UNKNOWN.

16. Informant: DONALD SHANNON.

Address: 912 SILVER SPRING AVE SILVER SPRING MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 5 1945. (month) (day) (year)

Cemetery ~~or crematory~~: ST JOHNS.

Location: FOREST GLEN - MONTG CO. MD

18. Funeral director: Adams & Pumphrey.

Address: 8434 GA. AVE SILVER SPRING - MD

19. June 4 1945 (Date rec'd by registrar) Josephine M Schaeffer registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 19 45 at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam. 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocarditis	4 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 6-3-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06210

Reg. Dist. No. 723

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hospital
How long in hospital or institution? 2 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1151 - 45th Pl, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Edith Nicholas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Wm. Ames Nicholas (deceased)
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 7, 1877

8. AGE: Years: 70 | Months: 11 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Chicago Illinois (town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Burchell
13. Birthplace: England

MOTHER
14. Maiden name: Taylor
15. Birthplace: England

16. Informant: Rep. to Washington San + Hospital
Address: Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/30/45 (month) (day) (year)

Cemetery or crematory: Washington, D.C.
Location: Matthew Hysong & Son
13. Funeral director: 1300 N.H. Ave. N.W. Washington
Address:

19. June 30 1945 (Date rec'd by registrar) J.W. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1945 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/16 1945 to 6/30 1945 and that I last saw h er alive on 6/29 1945

Immediate cause of death	DURATION
Pulmonary Congestion	2½ days
Due to Circulatory Failure	3 days
Due to Cardio - Vascular disease	Several Yrs.
Other conditions Cerebro - Vascular disease & old residual paralysis (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. A. Katz M.D. M. D. or other
Address: Wash. San + Hospital Takoma Park, Md. Date signed: 6/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

66211

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Montgomery County General Hosp.

How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Spencerville R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mr. Oscar Nichols

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

B.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 4, 1871

8. AGE:

Years	Months	Days	If less than one day
74	3	19	____ hrs. ____ min.

9. Birthplace: Norbeck, Md. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER — 12. Name: Charles Nichols

FATHER — 13. Birthplace: Montgomery Co. Md.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Olney, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25 1945 (month) (day) (year)

Cemetery or crematory: Salem

Location: Brookville Md.

18. Funeral director: Roy W. Barber

Address: Brookville Md.

19. 6-23 1945 (Date rec'd by registrar) Dudley B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1945, at 7:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1944, to June 22 1945 and that I last saw him alive on June 22, 1945 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	10 hrs.
Due to: Carcinoma Stomach	15 mths.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas E. Tumbleson M. D. or Coroner

Address: Sandy Spring Md. Date signed 6-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-C

06212

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
How long in U.S. if not born here?
Usual residence, or street address where death occurred:
7914 Georgia Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1501 - 16th. St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: none ✓

3.(a) FULL NAME: Jeanne M. O'Connor

3.(b) Social Security Number: 397-16-4201

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: X
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 26th. 1924

8. AGE: Years	Months	Days	If less than one day
21	2	24	hrs. min.

9. Birthplace: Milwaukee, Wis. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: Matthew J. O'Cannor
13. Birthplace: Milwaukee, Wis.

MOTHER
14. Maiden name: Florence O'Connor
15. Birthplace: Stoughton, Wis.

16. Informant: Mr. Florence O'Connor
Address: 2756 N. 18th. St. Milwaukee 6, Wis.

17. removal (Burial, cremation, or removal. Which?) Date thereof: June 3rd. 45 (month) (day) (year)
Cemetery or crematory: Mount Carmel
Location: Chicago, Cook Co. Ill.
18. Funeral director: Wame E Pumphrey
Address: 8434 Ga. Ave. Silver Spring. Md.

19. June 23 19 45 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/20/ 19 45, at 12.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Heart disease 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac dilatation	1 dy
Due to: Chronic Hypertension	2
Due to: Chronic Parenchymatous nephritis.	2 / 1
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Aby
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State) —
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: J W Bird Attending Pathologist
M. D. or other
Address: Sandy Spring Md Date signed: 6/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH

06213

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, writs RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Montgomery Co Gen Hosp.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Ellen Peters.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John H Peters
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): April 10, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	12	...hrs. ...min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: House work
11. Industry or business: "

FATHER
12. Name: John O'Rourke
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Ellen O'Rourke
15. Birthplace: Ireland.

16. Informant: Hospital Records.
Address: Olney, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/45 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: 4200 Old Frederick Rd.
18. Funeral director: Ernest C Gaither
Address: Gaithersburg Md

19. June 23 1945 Alfred J Cook Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 22 1945, and that I last saw her alive on June 22 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	8 days
Due to: Hypertension	2 yrs.
Due to:	
Other conditions	

(Incliode pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. J. Brochard M. D.
M. D. or other
Address: Gaithersburg md. Date signed 6-22-45


RECEIVED
JUN 27 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37a)

CERTIFICATE OF DEATH

06214

Reg. Dist. No. 231

1. PLACE OF DEATH:
County 506 Carroll Av. T MONTGOMERY
City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23- T. St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Joseph T. K. Plant

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Rosa E.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1873

8. AGE: Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Joseph T. K. Plant
13. Birthplace Unknown
MOTHER 14. Maiden name Louisa Marion Plant
15. Birthplace Unknown
16. Informant Donald B. Plant
Address 1002- 15th St. S. E. (Son
17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director The J. N. Hines Co
Address 2901- 14 St N W
19. 6/27 19 45 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27- 19 45 at 12:25 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1- 19 40 to June 26 19 45
and that I last saw him alive on June 26 19 45

Immediate cause of death	DURATION
Exhaustion	48 Hrs.
Due to Cerebral Hemorrhage	3 Years
Due to Cardio Renal Vascular Disease	Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Irwin D. Palmer M.D.
M. D. or other
Address 4313 Gallatin St Hyattsville Md Date signed 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2nd)

06215

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montg Co.
City or town: Near Germantown, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Germantown, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clara Bernarda Poole

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1848

8. AGE: Years	Months	Days	If less than one day
1848 97	1	16	hrs. min.

9. Birthplace: Frederick Co, Md
(Town, county, and state)

10. Usual occupation: Retired, Home work

11. Industry or business: "

FATHER
12. Name: Thorton Poole
13. Birthplace: Md

MOTHER
14. Maiden name: Rachel Owings
15. Birthplace: Md,

16. Informant: Mrs Robert Hickerson
Address: Germantown Md

17. Burial, cremation, or removal. Which?: Burial Town Date thereof: 6/28/45 (month) (day) (year)

Cemetery or crematory: St Peters Cemetery
Location: Libertytown, Md

19. Funeral director: Ernest C Gartner
Address: Gaithersburg Md

19 June 27 19 45 (Date rec'd by registrar) Abruda G Poole Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26th 19 45 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930 to June 26 19 45
and that I last saw h alive on June 23 19 45

Immediate cause of death	DURATION
Acute Myocardial	1/2 hr
Due to: Chronic Valvular heart disease	2 yrs
Due to: Hypertension	15 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

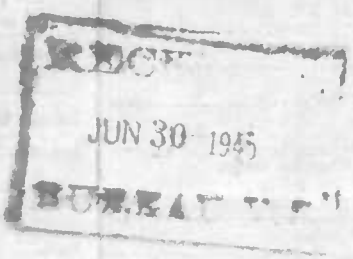
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M. D.
M. D. or other
Address: Gaithersburg Md Date signed 6-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


JUN 30 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0621[illegible]

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 805-Maple Ave

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7111- 8th St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: √

3.(a) FULL NAME: Nina N. Reynolds

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 17, 1872

8. AGE: Years: 72 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Troupburg, N.Y. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Alexander Prutsman; 13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Eliz Wilcox; 15. Birthplace: N.Y.

16. Informant: Home Records

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 6/20/45 (month) (day) (year)

Cemetery or crematory: Harmony [illegible]. D.C.

Location:

18. Funeral director: The S. H. Hines Co

Address: 2901-14-st N.W. Wash. D.C.

19. 6/20 1945 (Date rec'd by registrar) J. William Rodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20th 1945 at 12:40 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1945, to June 19 1945

and that I last saw h[illegible] alive on June 19 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	6 days
Due to: Arteriosclerosis	20 yrs.
Due to:	
Other conditions: Arthritis (rheumatoid)	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles J. Carroll M.D. M. D. or other

Address: 6801-6th St. N.W. Wash. D.C. Date signed: 6/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

06217

Reg. Dist. No. 723

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years.
Hospital, institution, or street address where death occurred:
301 Lincoln Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oobborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 301 Lincoln Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: SAMUEL RIGGLEMAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED.

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) NOV. 24, 1854.

8. AGE: Years	Months	Days	If less than one day
90	6	27	hrs. ____ min.

9. Birthplace: W. VA. (Town, county, and state)
10. Usual occupation: FARMER- GREENHOUSE MAN.
11. Industry or business: RETIRED.
12. FATHER — Name: HENRY RIGGLEMAN.
13. Birthplace: ?
14. MOTHER — Maiden name: SUSAN ?
15. Birthplace: ?
16. Informant: DR. R.L. RUNK
Address: 301 LINCOLN AVE.,
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 25, 1945. (month) (day) (year)
Cemetery or crematory: GEO WASH. MEMORIAL CEM.
Location: RIGGS RD. HYATTSVILLE, MD. PR.GEO. CO.
18. Funeral director: J. ARTHUR WALTERS
Address: 254 CARROLL ST. N.W. TAKOMA PARK, D.C.
19. June 27 1945 J. Milton Dodd Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 21, 1945, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 (year) to 6/19/45 and that I last saw h... alive on 6/19/45

Immediate cause of death	DURATION
a Myocardial failure due to	a few wk
b Arteriosclerotic heart	
Due to: Cerebral hemorrhage	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Chas A. Robbins 4th M.D. or other
Address: 5011 Tindwood St. N.W. Date signed 6/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1200)

CERTIFICATE OF DEATH

06218

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park Sub.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred: Walter Reed Hosp.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Takoma Park - Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6806 New Hampshire Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Frederick Charles Rupertis

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Evelyn Marie Rupertis
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Oct 14, 1908

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
36	8	17		

9. Birthplace: Wash. D.C. (Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: D.D. Engineer
FATHER 12. Name: Frederick Rupertis
13. Birthplace: Wash. D.C.
MOTHER 14. Maiden name: Ruth Elizabeth Matteu
15. Birthplace: Wash D.C.
16. Informant: Next of Kin
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof June 26-45 (month) (day) (year)
Cemetery or crematory: Washington D.C.
Location:
18. Funeral director: L. H. Hines Co.
Address: 2901-14th St. N.W.
19. June 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/26 1945, at 6 35 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/13 1945, to 6/26/1945
and that I last saw him alive on 6/25 1945

Immediate cause of death	DURATION
Accidental Coitus.	4/23/45
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None.
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Howard V. Moore M.D.
M. D. or other
Address: 24 Carroll Ave. Takoma Park, Md. Date signed: 6/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

0621

Reg. Dist. No. 2/3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, Institution, or street address where death occurred: 408 - East Montg Ave.
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 408 - E. Montg. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary J. Ryan.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louis J. Ryan
(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): June 21 - 1883

8. AGE:

Years	Months	Days	If less than one day
61	11	18	hrs. min.

9. Birthplace: Woodstock - Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: Samuel Thayer
13. Birthplace: Woodstock - Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Louis J Ryan (Husband)
Address: 408 - E. - Montg Ave Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 10/45 (month) (day) (year)
Cemetery or crematory: Rockville Union Cem.
Location: Nr. Rockville - Maryland
18. Funeral director: Wm. Reuben Pumphrey
Address: Rockville Maryland
19. 6/9/45 (Date rec'd by registrar) 19 Dolphine D. Hamilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 1945 - at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1945 to June 8 1945
and that I last saw h[illegible] alive on June 8 1945

Immediate cause of death	DURATION
Chronic valvular heart disease	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. O. Hartley, M.D. M. D. or other
Address: Rockville, Md Date signed: 6/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

T

06220

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years.

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 3½ hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4501 Leland Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Stant, Walter Roscoe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Gertrude Wyatt

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 15, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	27	..... hrs. ..... min.

9. Birthplace: Connersville, Indiana (Town, county, and state)

10. Usual occupation: clerk

11. Industry or business: War Dept.

FATHER 12. Name: unknown

13. Birthplace: Indiana

MOTHER 14. Maiden name: unknown

15. Birthplace: ?

16. Informant: wife

Address: 4501 Leland St.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 6/13/45 (month) (day) (year)

Cemetery or crematory: Kokomo, Ind.

Location: Ind.

18. Funeral director: Wm Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 6/12/45 (Date rec'd by registrar) Wm E Jobes MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2/4/45 1945, to 6/11 1945 and that I last saw h.. alive on 6/11/45 1945

Immediate cause of death	DURATION
Due to: coronary sclerosis & thrombosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J L Marks M. D. or other

Address: 4601 Leland St Date signed 6/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILED JUL 11 1945

06221

Reg. Diat. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Monty

City or town: Old Germantown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs

Hospital, Institution, or street address where death occurred: Boyds, Md. R.F.D. #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Boyds Md. R.F.D. #1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Stephens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

8.(b) Name of husband or wife: James A.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1877 1876

8. AGE: Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: James Ford

13. Birthplace: Va.

MOTHER 14. Maiden name: Ellen Frances Carter

15. Birthplace: Va.

16. Informant: Daniel F. Ford

Address: Brookeville, Boyds, Md. R.F.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/45 (month) (day) (year)

Cemetery or crematory: Beallsville Cem.

Location: Beallsville, Md.

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda

19. June 25 1945 (Date rec'd by registrar) Arnold G. Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22, 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 28 1945, to June 22 1945

and that I last saw h.er alive on June 22 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 4-3 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Md. William B. Miller, M.D.

M. D. or other

Address: Gaithersburg, Md. Date signed 6/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06222

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery Bureau

City or town Metropolitan Town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sixty Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Metropolitan Town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucy Stevenson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife Elisha Stevenson

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb 10 1874

8. AGE: Years 69 | Months 3 | Days 30 | If less than one day ____ hrs. ____ min.

9. Birthplace Montgomery Co Md
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

FATHER 12. Name Samuel Johnson

FATHER 13. Birthplace Montgomery Co Md

MOTHER 14. Maiden name Rachel Ann Mitchell

MOTHER 15. Birthplace Montgomery Co Md

16. Informant William Stevenson

Address Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (month) (day) (year)

Cemetery or crematory Emory Grove Md

Location Montgomery County Md

18. Funeral director Roy W Barber

Address Laytonsville Md

19. June 11 1945 (Date rec'd by registrar) Alsada S. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1945, at 1-P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1945, to June 8 1945

and that I last saw h... alive on June 8 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Gaithersburg Md Date signed June 11 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

6223

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Barnstown Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Herbert F. Stabler

3. (b) Social Security Number: 224-03-6482

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

8.(b) Name of husband or wife: Cora Lee Stabler

8.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Jan 10 - 1905

8. AGE:

Years	Months	Days	If less than one day
40	5	7	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Bus driver

11. Industry or business

FATHER

12. Name: John W. Stabler

13. Birthplace: Virginia

MOTHER

14. Maiden name: Fannie Pinkman

15. Birthplace: Virginia

16. Informant: Chart

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jun (month) 19 (day) 1945 (year)

Cemetery or crematory: Barnstown Md

Location: Montgomery Co Md

18. Funeral director: Roy W. Barber

Address: Laytonsville Md

19. 6/18 (Date rec'd by registrar) 19 45 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 19 45 at 11 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 45, to June 17 19 45 and that I last saw h... alive on June 17 19 45

Immediate cause of death: Confluent Lobular Pneumonia — DURATION

Due to:

Due to:

Other conditions: Chronic Catarrhal Bronchitis Chronic Bronchiectasis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: See Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Richard E. Kelso M.D. M. D. or other

Address: Bethesda, Md Date signed: 6-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486) K

06224

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 6 mos 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2521 Forrest Glen Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Eugenia Talbott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	9	hrs. min.

9. Birthplace Meadow, New York (Town, county, and state)

10. Usual occupation Practical Nurse

11. Industry or business Private

FATHER 12. Name —

13. Birthplace —

MOTHER 14. Maiden name —

15. Birthplace —

16. Interment Rec'ds Washington Sanit. Hospital

Address Takoma Park, Md.

17. Removal- (Burial, cremation, or removal. Which?) Date thereof 6/2/45 (month) (day) (year)

Cemetery or crematory

Location Washington D. C.

18. Funeral director A. H. Hines Co

Address 2901-14 St. N.W.

19. June 2 1945 (Date rec'd by registrar) J. W. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1944, to June 2 1945

and that I last saw h[illegible] alive on June 1 1945

	DURATION
Immediate cause of death Carcinoma of Uterus	
Metastasis to Liver & all	
glands of Abdomen -	
Due to Pelvic Coronary Thrombosis	Past 42
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations 4-5-43 - Sub-total Hysterectomy Hysterectomy removal of Cervix Date of op. 11-27-44

Autopsy results Mets + Ca Abdomen - specimen

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Mitchell MD (M. D. or other)

Address Silver Spring Md. Date signed 6-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06225

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 min
Hospital, institution, or street address where death occurred:
Walter Reed Gen Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Dauphin
City or town Harrisburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1114 North St
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Nedra M. Tate

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	N.	Married

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 15, 1914

8. AGE: Years 31 | Months 2 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace New Cumberland Pa
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

FATHER
12. Name Daniel Witmer
13. Birthplace Pa.

MOTHER
14. Maiden name Bessie Neidhamer
15. Birthplace Pa.

16. Informant Mrs Bessie Witmer
Address Shippensburg, Pa.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 9 1945 (month) (day) (year)
Cemetery or crematory Rolling Green
Location Lemoyne Pa

16. Funeral director Warren E. Pumphrey
Address Silver Spring Md

19. June 9 1945 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8/45, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Hemorrhage	
Collapse Left lung Fibrosis	
(b) 9 & 10 Left ribs Perforating	
Due to Spleen Multiple abscess	
& Laceration of Stomach	
Due to & Extensive	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 6/8/45
Where did injury occur? Wilton Montg Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Highway
Means of injury Auto accident Injured at work? No

23. SIGNATURE [illegible] Cert Path.
M. D. or other
Address Sandy Spring Md Date signed 6/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-f-k)

CERTIFICATE OF DEATH

66226

Reg. Dist. No. 213-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural R.F.D. Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs - 6 mos.

Hospital, Institution, or street address where death occurred:
Nursing Home - Shady Grove Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Homes Lane
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Nellie Virginia Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thos. Robert Taylor

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 2 - 1870

8. AGE:

Years	Months	Days	If less than one day
75	3	28	..... hrs. ..... min.

9. Birthplace: Montg Co - Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Richard Thomas Arnold
13. Birthplace: Maryland

MOTHER
14. Maiden name: Umbenhower
15. Birthplace: Maryland

16. Informant: John W. Taylor - son
Address: Homes La. Rockville - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2-45 (month) (day) (year)

Cemetery or crematory: Church Cemetery

Location: Dickerson - Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Rockville - Maryland

19. 7/1/45 (Date rec'd by registrar) 19 Josephine D. Thalton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1945, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1945, to June 30 1945 and that I last saw her alive on June 29 1945

Immediate cause of death: Carcinoma of liver, unknown — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. P. Hartley, M.D. M. D. or other

Address: Rockville, Md. Date signed 7/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

06227

Reg. Dist. No. 213-

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Monty. Gen.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Monty.
City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Horners La.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas William Taylor

3.(b) Social Security Number: 577-22-9674

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 28, 1925

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
19	7	28		

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Box Factory
11. Industry or business:
FATHER 12. Name: John W. Taylor
FATHER 13. Birthplace: Seneca, Md
MOTHER 14. Maiden name: Annie E. Taylor
MOTHER 15. Birthplace: Gaithersburg, Md
16. Informant: Mrs. Annie E. Taylor
Address: Rockville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/27/45 (month) (day) (year)
Cemetery or crematory: Forest Oak Cem.
Location: Gaithersburg, Md.
18. Funeral director: Wm Reuben Pumphrey
Address: Rockville, Md.
19. 6/26/45 (Date rec'd by registrar) Josephine D. Shelton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945 at 1:18 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3rd Recent Case 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death	
Inter cranial hemorrhage	Instantly
Due to: Fracture of skull (accidental)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 6-25-45
Where did injury occur? Rockville (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): Street
Means of injury: Auto-accident Injured at work? No

23. SIGNATURE: Frank J. Bonhart M.D. M. D. or other
Address: Gaithersburg, Md. Date signed: 6-26-45

M

I

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06228

Reg. Diat. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Poolesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Poolesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Franklin Titus

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Annie V. Titus
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb 11 - 1877

8. AGE: Years	Months	Days	If less than one day
68	4	7	...hrs. ...min.

9. Birthplace Frederick County Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Edward L. Titus
13. Birthplace Maryland
MOTHER 14. Maiden name Mary C. McKinney
15. Birthplace Maryland
16. Informant James Titus
Address Poolesville Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof 6/21/45 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville Rte 1
18. Funeral director William B. Hellen
Address Barnesville Md
19. June 20 19 45 Charles E. Elgin Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/21 19 43, to 6/18 19 45
and that I last saw h. alive on 6/18 19 45

Immediate cause of death	DURATION
Cardio-Vascular Renal Disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Byron D. Whitt, M.D.
M. D. or other
Address Poolesville, Md Date signed 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164C)

CERTIFICATE OF DEATH

0622?

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month 9 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? one month nine days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1400 Cathedral Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WALKER, Charles Neill, Lt.Comdr. USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Martha Sater Walker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 14 July 1903

8. AGE: Years	Months	Days	If less than one day
41	11	14	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: Charles S. Walker

13. Birthplace: Va. (deceased)

MOTHER — 14. Maiden name: Martha Neill

15. Birthplace: Va. (deceased)

16. Informant: Wife: Mrs. Martha Sater Walker

Address: 1400 Cathedral Avenue, Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7-17-45 (month) (day) (year)

Cemetery or crematory: arlington national

Location: Arlington, Va.

18. Funeral director: Geo. W. Wise, Undertaker F.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 7-14 (Date rec'd by registrar) 19 45 mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (About) June 28 1945, at Naval Hospital

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. Med. Exam 19 to case 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death	
Bullet wound Thru skull	Instant dead
Due to (Suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of 6-28-45

Where did injury occur? Bethesda (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Revolver shot Injured at work? no

23. SIGNATURE: Frank J. Brockhurst M.D. Def. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed 7-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 7/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

06230

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No. R # 5 Nr. Damascus
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Mary L. Watkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married.

6.(b) Name of husband or wife: Alonza C Watkins

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): March 9, 1870

8. AGE:

Years	Months	Days	If less than one day
75	3	19	....hrs. ....min.

9. Birthplace: Damascus, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home.

FATHER
12. Name: Milton Boyer
13. Birthplace

MOTHER
14. Maiden name: Elizabeth Purdum
15. Birthplace

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 30 1945 (month) (day) (year)

Cemetery or crematory: Damascus, Md.

Location: Mont County, Md.

18. Funeral director: Roy M Barber

Address: Laytonsville Md.

19. 6-28-1945 Gertrude Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/28/ 1945, at 6a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/27/ 1945, to 6/28/ 1945 and that I last saw h[er] alive on 6/27/ 1945

Immediate cause of death	DURATION
Acute cardiac dilatation	1 Day.
Due to: Chronic Myocarditis with Hypertension	2 yrs
Due to: Gangrene left leg	10 Days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M D
M. D. or other

Address: Sandy Spring, Md. Date signed: 6/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

06231

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:
County: Montgomery
City or town: Browningsville, (near Damascus)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, Institution, or street address where death occurred: R. F. D. Monrovia,
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Browningsville,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. Monrovia,
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: REBECCA Zera WATKINS

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Bradley Watkins deceased
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 14, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	10	..... hrs. ..... min.

9. Birthplace: Montgomery Co. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Rev. C. J. Burdette
13. Birthplace: Montgomery Co., Md.

MOTHER
14. Maiden name: Roberta King
15. Birthplace: Montgomery Co., Md.

16. Informant: Howard W. Watkins
Address: Damascus, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26, 1945 (month) (day) (year)
Cemetery or crematory: Bethesda
Location: Brownsville, Md.

18. Funeral director: J. B. Beall Inc.
Address: Damascus, Md.

19. June 26 1945 (Date rec'd by registrar) Della A. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945 at 3:07 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1935 to June 24, 1945
and that I last saw her alive on June 24, 1945

Immediate cause of death	DURATION
Coronary Occlusion (Acute)	June 24
Coronary sclerosis	2 months
Due to: Generalized arteriosclerosis	5 years
Due to: Hypertension	10 years
Due to: Hypertensive heart disease	10 years
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

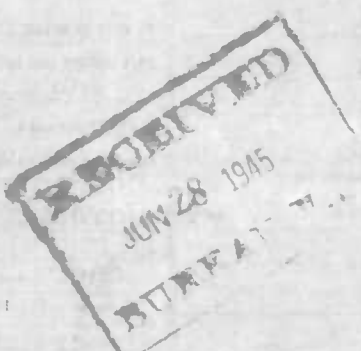
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. McKendree Boyer M.D.
M. McKendree Boyer, M.D. (Physician or other)
Address: Damascus, Maryland Date signed: 6/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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JUN 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06232

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 4 days

Hospital, Institution, or street address where death occurred:
U. S. N. Hosp.

How long in hospital or institution? 3 mos. 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County:

City or town: Phillippi
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME
Cora Gertrude WEBSTER, Y2c V-10 USNR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	Married

6.(b) Name of husband ~~wife~~: Henry Webster

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18, 1923

8. AGE: Years	Months	Days	If less than one day
22	0	0	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER 12. Name: Russell Max Hyre

13. Birthplace: West Virginia

MOTHER 14. Maiden name: Rachel Scott

15. Birthplace: West Virginia

16. Informant: Father: Russell Max Hyre

Address: Phillippi, West Virginia

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-21-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers

Address: Georgetown, D.C.

19. 18 June 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 June 1945, at 0005 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945, to June 18 1945

and that I last saw h~~er~~ alive on June 18 1945

Immediate cause of death	DURATION
Leukaemia, Acute Myelogenous	3 months
Cerebral Hemorrhage	24 hrs.
Due to	
Due to	
Other conditions: Bronchopneumonia, Splenomegaly	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harriet J. Davis, M. D. or other

Address: US Naval Hospital, Bethesda Md. Date signed: 6-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 ✓

Rec'd 6/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18a

06233

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Olney
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days.

Hospital, institution, or street address where death occurred: Montg. Co. Gen. Hosp. Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Janie A. Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Elmer Wilson

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) April 22, 1876.

8. AGE: Years	Months	Days	If less than one day
69	1	29	...hrs. ...min.

9. Birthplace Plymouth, Ohio
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Solomon Ludwig

13. Birthplace Bucyrus Ohio

MOTHER 14. Maiden name Julia Anna Ludwig

15. Birthplace Plymouth, Ohio

16. Informant Hospital Records

Address Olney, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23 1945 (month) (day) (year)

Cemetery or crematory Wesley Grove

Location Woodfield Md

18. Funeral director Roy W Barber

Address Poolesville Md

19. 6-22-45 (Date rec'd by registrar) Gertrude Fawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1945 19... at 10:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6/11/45 to 6/21/45

and that I last saw her alive on 6/21/45

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to Fractured Left femur	11 days
Due to Hyp.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/11/45

Where did injury occur? Gaithersburg (City or town) Md (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fractured Hip Injured at work? No

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring Md Date signed 6/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

116234

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Fairland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? From Nov. 3, 1940
Hospital, institution, or street address where death occurred:
Cedarcroft Sanitarium
How long in hospital or institution? From Nov. 3, 1940

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Col. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1741 Irving St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EMMA FILENA WILCOX

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	widowed

6.(b) Name of husband or wife: George Edward Wilcox
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 4, 1862

8. AGE: Years	Months	Days	If less than one day
82	10	8	hrs. min.

9. Birthplace: Maine (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER 12. Name: Samuel Clement
13. Birthplace: unknown
MOTHER 14. Maiden name: Mary ---
15. Birthplace: unknown
16. Informant: Edward C. Wilcox (Son)
Address: 1741 Irving St. N.W.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 6/14/45 (month) (day) (year)
Cemetery or crematory: CEDAR HILL
Location:
18. Funeral director: Martin W Bysong
Address: 1300 N St. NW Wash. D.C.
19. June 13 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION P.M

20. DATE OF DEATH: June 12 19 45, at 6.40/ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 — 1940, to June 12 — 1945; and that I last saw her alive on June 12 — 1945.

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to:	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard B. Thibadeau M.D. M. D. or other
Address: Cedarcroft Sanitarium Date signed: 6/12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06235

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Dist. No. 213.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Rockville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? /
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Dearwood not Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wade Yankey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) January 9 - 1929

8. AGE: Years	Months	Days	If less than one day
16	5	14	... hrs. ... min.

9. Birthplace Gaithersburg md (Town, county and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Roy A Yankey
13. Birthplace Rockville Md

MOTHER
14. Maiden name Martha Wetzel
15. Birthplace Rockham Co Va

16. Informant Roy A Yankey
Address Rockville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 27 1945 (month) (day) (year)
Cemetery or crematory Flower Hill
Location Redland md

18. Funeral director Roy W Barber
Address Laytonsville md

19. June 26 1945 Josephine D. Shelton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27/45 at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Autopsy 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Communicated Fracture of Skull and Intra-	
Due to Cranial Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 6/27/45
Where did injury occur? Rockville Montg Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Highway
Means of injury Auto accident Injured at work?

23. SIGNATURE ... Asst Pathologist
M. D. or other
Address ... Date signed 6/27/45